DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11039A (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / SPELL OF ILLNESS ATTACHMENT (PA/SOIA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of the Prior Authorization/Spell of Illness Attachment (PA/SOIA) is voluntary when requesting spell of illness (SOI). Providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Attach the completed PA/SOIA to the Prior Authorization Request Form (PA/RF) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

An SOI ends when the maximum allowable treatment days have been used or when the physical therapy (PT), occupational therapy (OT), or speech and language pathology (SLP) services are no longer required, whichever comes first. If, near the end of the maximum allowable treatment days, the skills of a PT, OT, or SLP provider are still needed, the provider should submit the PA/RF and the Prior Authorization/Therapy Attachment (PA/TA) to continue services.

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters in this field.

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Therapist
Enter the name and credentials of the primary therapist participating in therapy services for the recipient. If the performing provider is a therapy assistant, enter the name of the supervising therapist.

Element 5 — Therapist's Medicaid Provider Number
Enter the performing provider's eight-digit provider number. If the performing provider is a therapy assistant, enter the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider.

Element 6 — Telephone Number — Therapist
Enter the performing provider's telephone number, including the area code, of the office, facility, or place of business. If the performing provider is a therapy assistant, enter the telephone number of the supervising therapist.

Element 7 — Name — Prescribing Physician
Enter the name of the prescribing physician.

SECTION III — DOCUMENTATION

Element 8
Enter an "X" in the appropriate box to indicate a PT, OT, or SLP SOI request.

Element 9 — Requested Start Date
Enter the requested start date for service(s) in MM/DD/YY format (e.g., June 30, 2003, would be 06/30/03).

Element 10 — Primary *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) Diagnosis Code or ICD-9-CM Surgical Procedure Code
Enter the appropriate primary ICD-9-CM diagnosis code or surgical procedure code.

Element 11
Enter an "X" in the appropriate box to indicate "yes" or "no" in response to each statement. Only one of "A" through "F" must be marked "yes" in addition to "G" for SOI approval. Otherwise, the PT, OT, or SLP provider should submit the PA/RF and the PA/TA.

Element 12 — Signature — Therapist Providing Evaluation / Treatment
The signature of the therapist providing evaluation/treatment must appear in the space provided.

Element 13— Date Signed
Enter the month, day, and year the PA/SOIA was signed in MM/DD/YY format.